

U.S. Department of State

SPECIAL SEATING REQUEST FORM FOR BUSINESS CLASS AIR TRAVEL

Employee Name			
	Last	First	Middle
Organization	Millennium Challenge C	Corporation	
Name of Attendan	ts if Required:		
Name			
	Last	First	Middle
Name			
	Last	First	Middle
Name			
	Last	First	Middle
Approved By: (Che	ck if M/MED or Identify POST)	(Print Name)	
		(r mic rvamo)	
	Signature of	M/MED or RMO/FSNP	
	Print Name	of Approving Official	
	Date signed (mm-dd-yyyy)		

U.S. Department of State

BUSINESS CLASS UPGRADE - MEDICAL QUESTIONNAIRE

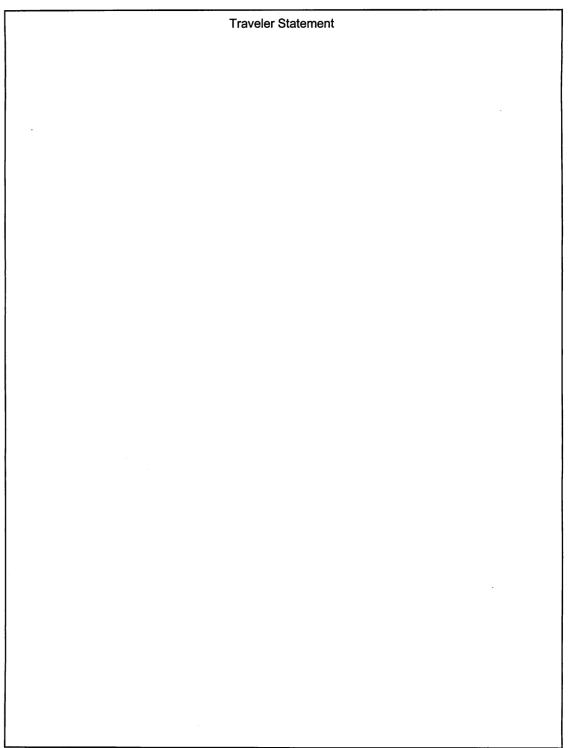
For the traveler

(a) Release of information - Please sign and date the authorization printed for release of information from your physician.
"I hereby authorize my physician to provide the information requested below to the Domestic Programs, Office of Medical Services, U.S. Department of State and to provide requested information verbally and in writing regarding my medical or mental health condition(s) as it pertains to my request for a premium travel upgrade". Date (mm-dd-yyyy) Traveler's Signature Traveler's Name (Last, First, MI) City Home Address State ZIP Code Work Phone Home Phone **Primary Email** Secondary Email (b) Traveler Statement - On the next page, you may explain your specific difficulties requiring business class or a premium travel upgrade. (c) Have your physician document the information requested and sign this form. Alternatively, the information can be provided on signed letterhead.

(d) Email this form as a scanned pdf attachment to medDP@state.gov. Alternatively, it can be faxed to attention: Domestic Programs, 202-663-1687.

DS-4086A 08-2011

Page 1 of 5



DS-4086A

Please take this form to your treating physician.				
Your patient is requesting business class travel or a premium travel upgrade for a medical condition. Determinations are on the basis of a medical need, not traveler comfort. We are requesting your assistance in determining if your patient has a medical condition necessitating business class travel.				
Please provide the following information:				
1) Diagnosis and current medical condition of your patient.				
2) Current treatment regimen for this condition including current medications.				
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3) What impact would air travel likely have on your patient if no special accommodations were made?				

DS-4086A Page 3 of 5

Which of the following modalities may your patient use during commercial air travel? (Please check each one that applies.)
a. Frequent standing b. Walking and moving about the cabin c. Frequent in-seat stretching d. The use of support stockings (thigh high or full length) e. Aisle seating f. Exit row seating g. Bulkhead seating h. Medications
5) If your patient utilized the above modalities, how would your patient likely be affected by air travel? What, if any, adverse effects would your patient be likely to have as a result of air travel while using the above modalities?
6) If the modalities noted in number 4 were available to your patient, please specify what, if any, additional accommodation/modalities you recommend for air travel? What, if any, adverse effect is your patient likely to have as a result of air travel using the additional modalities you recommend?
7) Do you recommend business class travel for your patient? If so, why and what is accomplished by business class travel that is not accomplished by the modalities noted in number 4?

DS-4086A

B) Does duration of travel affect your patient's medical condition with or without the accommodation? If so, is there any length or type of travel that you recommend that your patient not undertake because it would adversely affect his/her medical condition?		
9) What is the patient's proto last?	gnosis? How long is the current	medical condition expected
-	ditional information supporting youts, x-ray results and laboratory te	•
11) Please sign and date the	nis form as follows:	
Physician's Signature		Date (mm-dd-yyyy)
Physician's Printed or Typed Name and Degree		Phone
Address		
City	State	ZIP Code
requesting or requiring genetic information comply with this law we are asking that 'Genetic information' as defined by GIN	on of an individual or family member of the individual on the individual on NOT provide any genetic information when re A, includes an individual's family medical history,	mployers and other entities covered by GINA Title II from dual, except as specifically allowed by this law. To sponding to this request for medical information. the results of an individual's family member's genetic tic services, and information of a fetus carried by an

DS-4086A Page 5 of 5